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1401 Foster Care and Adoption

RESERVED

1402 Ventilator Dependent

1402.1 Overview

In accordance with the requirements of the ALTCS Program, DES/DDD will provide comprehensive, coordinated, cost-effective ALTCS covered services which will further the goal of maintaining the ventilator dependent individual in the most natural and medically/socially appropriate environment designed to maximize the individual's eventual weaning from both mechanical and intense medical dependence.

A ventilator dependent individual is one who is medically dependent upon a mechanical ventilator for life support at least six (6) hours per day and has been dependent on ventilator support for at least thirty (30) consecutive days. During the 30 day period, the individual may have been living in either a hospital, Nursing Facility (NF), Intermediate Care Facility for the Cognitive Disabled (ICF/MR) or a home and community based setting. Intermittently dependent individuals may not be classified as ventilator dependent individuals, however, they can receive long term care services if they are otherwise eligible as non-ventilator dependent individuals.

1402.2 Service Description and Goals

The goal of service to ventilator dependent individuals is to provide medical, mechanical and support services in compliance with ALTCS regulations to maintain the individual in the most medically/socially appropriate environment designed to maximize eventual weaning from mechanical dependence.

Goals for ventilator dependent individuals and their families include:

a. to provide services to persons with developmental disabilities who are ventilator dependent in the most natural and socially/medically appropriate placement;

b. to assure that care is of high quality, cost effective and appropriate for ventilator dependent individuals and consistent with ALTCS regulations;

c. to assist families, where feasible, in maintaining placement of their ventilator dependent individuals at home;

d. to improve the informal and formal support network of individuals and/or families with ventilator dependent individuals;

e. to promote independence of individuals who are ventilator dependent from both mechanical devices and caregivers as much as possible;

f. to encourage development of further resources through community support; and

g. to assure that Individual Support Plans (ISPs) are developed and coordinated with the Primary Care Physician (PCP) to assure appropriate utilization of acute and long term care services.

1402.3 Service Settings

Services may be provided in the individual's own home, a child developmental foster home, adult developmental home or institution.

1402.4 Service Requirements

Upon notification by ALTCS of the individual's date of determination or date of enrollment, the individual will be assigned to a Support Coordination Team (CT). The CT is composed of a Support Coordinator and a registered nurse (RN). The Support Coordinator is a DES/DDD Support Coordinator employed in the District in which the individual resides. The RN is employed in Central Office Managed Care Operations (MCO).

The RN member of the CT will:

a. open all new cases and coordinate initial discharge of the individual from hospital/institutional placement; initiate the ISP with CT Support Coordinator,

identifying all acute care providers and long term care service needs and the cost and scope of services to be provided;

b. assure the care of the ventilator dependent individual is appropriate and in compliance with ALTCS regulations;

c. make on-site visits to ventilator dependent individuals every 30 days to ensure the ISP is being implemented and that services are necessary and cost effective;

d. make on-site visits when notified that there has been a change in the level of care of a ventilator dependent individual;

e. on a monthly basis, jointly document with the CT Support Coordinator:

1. the health status of the ventilator dependent individual;

2. visits to the physician and changes in the treatment plan;

3. problems which have been identified which involve the health of the individual and recommendations for resolution; and

4. continued eligibility as ventilator dependent.

One copy of the Monthly Visit Report (Part II) (Appendix 1400.A) is filed in the individual's chart kept by the RN; one copy is filed in the Support Coordination file;

f. coordinate covered services with the health plan;

g. assist families/caregivers to understand the procedure, through the MCO Prior Authorization unit, to order approved medical equipment and supplies and adaptive aids;

h. submit a Cost Effectiveness Study (CES) (Appendix 600.D) on the individual's services on a monthly basis to the MCO Medical Services Manager and the individual's file and review the CES with the MCO Medical Services Manager;

i. submit ALTCS Member Change Form (Appendix 900.B) for any changes in demographics, placement or eligibility of the ventilator dependent individual for the ventilator program;

j. submit service authorization forms to the Support Coordinator or delegated data entry staff for data entry for nursing and respite services;

k. work with providers and individuals/families to resolve issues involving nursing/medical services;

l. attend ISPs, IEPs, IFSPs and foster care review boards when pressing issues need to be resolved;

m. submit notification of hospitalization to Business Operations to initiate potential reinsurance submission;

n. draft response for the Managed Care Operations Director to AHCCCS requests for corrective action resulting from bi-yearly audits or quality concerns;

o. submit monthly status reports to Research Analyst in Business Operations regarding hospitalizations, client count and services over capitation; and

p. submit, to the Managed Care Operations Director, an annual cost analysis of ventilator dependent program expenditures.

The Support Coordinator on the SCT will perform all Support Coordination duties as noted in this manual. Additionally, the Support Coordinator will:

a. make on-site visits with the RN every month to ensure the ISP is being implemented;

b. jointly document, monthly, with the SCT RN, the following:

1. services authorized and received and, if applicable, the reasons a service was not rendered;

2. the ISP goals and the progress made toward meeting the goals and/or the barriers impeding goal attainment; and

3. problems involving non-nursing issues and recommendations for resolution.

One copy of the Monthly Visit Report (Part I) (Appendix 1400.B) is filed in the Support Coordination file; and one copy is filed in the RN's case file.

c. obtain agreement from the RN before requesting a change in non-nursing services. Submit paperwork necessary to institute and maintain all approved non-nursing services. Make all arrangements to secure non-nursing provider(s);

d. notify emergency services and utilities initially and for changes of residence for the ventilator dependent individual; and

e. notify RN when ventilator dependent individual is hospitalized.

The SCT is responsible to:

a. assist the individual and/or appropriate others in solving problems regarding the ISP goals;

b. inform the individual and/or appropriate others regarding their appeals, hearing, and/or grievance rights; and

c. facilitate access to services and benefits as needed.

Ventilator dependent individuals are eligible to receive both acute and long term care ALTCS covered services which will maximize their health and independence.

a. acute care services:

Acute care services are provided by the health plan (including Indian Health Services (IHS)) with which the ventilator dependent individual is enrolled according to DES/DDD policy. All individuals choose or are assigned a Primary Care Physician (PCP) who is responsible for ordering all medical services.

The health plan is responsible for authorizing and managing all contracted acute care services provided to the individual on a 24-hour/7 days a week basis. The health plan notifies DES/DDD Managed Care Operations (MCO) when individuals are hospitalized or utilize non-routine, high cost services. This notification is based on services authorized, not claims paid, and should be reported within two working days of the service. (IHS follows DES/DDD mandated policy/procedure for prior authorization of services provided by non-IHS facilities/providers.) Charges for acute care services provided by the health plan are reimbursed by DES/DDD

upon submission of mandated claim forms by the health plan.

b. Long Term Care Services:

The SCT is responsible for assessment of service need and the coordination and monitoring of service provision. The RN member of the SCT has final approval authority for all services (acute and long term care) provided to the ventilator dependent individual.

It is DES/DDD's goal, to the extent possible, that primary caregivers develop as much independence as possible with respect to ongoing care of ventilator dependent individuals.

DES/DDD assumes that in natural home settings, utilizing in-home supports, the primary responsibility for care resides with the family and that the family will play a significant ongoing role in the delivery of day-to-day care with the assistance of professional and non-professional support personnel.

Designated district personnel are responsible to reimburse claims for long term care services using appropriate funding streams.

1402.5 Target Population

An individual is eligible for ventilator dependent services if the individual is financially, medically and functionally eligible as determined by the Pre-Admission Screening (PAS) and meets the definition of ventilator dependent as described in Section 1402.

The PAS determines the range and degree of the individual's medical condition and functional abilities and if the individual's level of care is Class 4 (ventilator dependent).

1402.6 Exclusions

Individuals must meet eligibility as ventilator dependent as previously noted. Services must be ALTCS covered. Cost of services must not exceed 100% of the cost of institutionalization without a plan in place to reduce the cost of services to less than 100% of the cost of institutionalization within a six (6) month period.

The home and community based services included in the cost effectiveness study to determine costs as a percent (%) of institutionalization are:

a. adult day health;

b. attendant care;

c. home health nurse/aide;

d. homemaker;

e. respite (if provided on a regular basis, i.e., 4 hours. per week);

f. medically necessary transportation (if provided on a regular basis, i.e., 3 trips per week for dialysis); and

g. non-customized DME which is included in a NF per diem and whose aggregate cost exceeds $200, regardless of purchase or rental, i.e., wheelchairs, walkers, hospital bed, etc.

Services NOT included in the cost effectiveness study include:

a. hospice services;

b. customized DME;

c. therapy services (physical, occupational, speech and respiratory);

d. medical supplies and drugs;

e. mental health services.

DES/DDD is capitated by AHCCCS for ventilator dependent individuals. If costs for all services, those included in the CES and those not included in the CES, exceed capitation all services will be reviewed by the MCO Medical Services Manager for potential change.

1402.7 Service Provision Guidelines

The Support Coordination Team (SCT) will be assigned within two (2) working days of notification of enrollment in ALTCS from AHCCCS. The SCT must arrange for services begin as soon as possible.

a. telephone contact to the family must be initiated within five (5) working days of date of notification of enrollment or date of ventilator dependent status determination;

b. appropriate service delivery must begin within 10 working days of enrollment or notification of ventilator dependent status;

c. the ISP must be entered into CATS (AHCCCS automated system by the RN within ten (10) working days of service delivery;

d. on-site visits must be made every 30 days or more frequently when the individual's medical status changes. If the visit cannot be made within 35 days, the reason(s) must be clearly documented in the Support Coordination file and the visit rescheduled as soon as possible. The RN will complete an Untimely Visit Report (Appendix 1400.C) and submit a copy to the ALTCS Ventilator Dependent Coordinator; and

e. updates of changes related to placement, level of care, or services on the ISP must be submitted to the ALTCS Ventilator Dependent Coordinator within five (5) working days of the change.

In addition to the requirements noted in Section 1808, documentation to be maintained by the SCT includes:

a. the authorized amount of services, in the client case notes;

b. the individual's progress toward established goals, and identification of barriers and/or achievements;

c. validation of services actually received as documented during the on-site visit;

d. validation that the client continues to meet minimum ventilator dependent criteria; and

e. all contacts by the SCT with caregivers, PCP, providers, the individual, etc.

1402.8 Provider Types and Requirements

Ventilator dependent individuals will be enrolled with the health plan of their choice as available in their residence zip code. The health plan is responsible to authorize and reimburse acute care services provided to ventilator dependent members through the health plan provider network and according to health plan policy and procedure for utilization management. Capitation will not be paid for ventilator dependent members to the health plan.

DES/DDD is responsible to reimburse the health plan for these services at the lesser of the health plan's negotiated rate with DES/DDD or the AHCCCS capped fee-for-service rate schedule.

Health plan responsibilities include:

a. accept ventilator dependent enrollees by member's rate code and ventilator dependent plan number;

b. assign each member to a PCP, accepting member choice of PCP when possible;

c. identify a health plan staff member to work with the DES/DDD SCT in coordinating services to ventilator dependent members;

d. educate health plan providers about provision of services to members;

e. notify MCO Prior Authorization Nurse within one working day of utilization of hospitalization or non-routine high cost service, i.e., ambulance, prescription exceeding $100, etc.; and

f. work with the SCT to facilitate provision of services included in the comprehensive discharge plan. Although the health plan is not financially responsible for long term care services, many covered medical services may need to be authorized and provided by the health plan.

DES/DDD responsibilities include:

a. DES/DDD assigns a SCT to each ventilator dependent member. This team is responsible to coordinate all care provided to the member. This team will work with the health plan identified staff person to coordinate health plan authorized services;

b. the DES/DDD District and the SCT will have a contingency plan for addressing the non-availability of trained care providers. The plan should addresss holiday shortages, emergency situations, and shortages due to highly specialized care. The plan must have a back-up system which assures that the necessary level of care can be maintained and that primary caregivers are aware of the back-up systems; and

c. if third party liability (TPL) exists to cover a ventilator dependent individual, services should be coordinated through the third party to avoid costs to DES/DDD. TPL covered services shall be included on the ISP.

Additional DES/DDD covered services shall not exceed service need parameters established by the ISP Team. For example, if it is assessed that an individual needs six (6) hours per day of personal care and TPL is paying for twelve (12) hours per day of skilled nursing, DES/DDD will provide no additional personal care services. If TPL terminates, DES/DDD will initiate 6 hours per day of personal care if the individual continues to need that level of service.

1402.9 Service Evaluation

Monthly, Business Operations will prepare a ventilator dependent services cost report. This report will be used, with the CES prepared by the SCT, in the overall management of the program.

As DES/DDD is capitated for ventilator dependent members, it is critical to monitor costs of services in the aggregate, as well as on individual bases. Financial issues should not drive service provision except when aggregate expenses exceed total capitation.

Additionally:

a. providers must submit a monthly written progress report on ISP objectives to the SCT. The report must address the presence or absence of measurable progress toward the individual's goals and objectives; and

b. the SCT must perform a review of the ISP as noted in Chapter 100.

1402.10 Service Closure

Individuals may be terminated from the program if:

a. the individual no longer meets the definition of Ventilator Dependent;

b. the individual dies;

c. the individual, family or guardian requests disenrollment; or

d. the individual moves out of state.

When an individual is terminated from the program, the SCT must:

a. identify and document reasons for closure;

b. identify and record the individual's status at close of services, including progress toward his/her goals;

c. when requested, provide the individual's records for review by the PCP or DES/DDD Medical Director;

d. as appropriate, provide referral information on optional services to meet the needs of individuals no longer eligible for ALTCS; and

e. provide updated Support Coordination information, including service completion or change in level of care to AHCCCS within five working days. The AHCCCS PAS Team will complete a PAS reassessment and change the member enrollment consistent with AHCCCS policy.

A Notice of Intended Action must be sent in accordance with the processes defined in Section 2202 of this Manual.

1403 Behavioral Health

1403.1 Overview

The Department of Economic Security/Division of Developmental Disabilities (Division) shall provide behavioral health services to persons with developmental disabilities who are determined eligible for the Arizona Long Term Care System and who are determined to need behavioral health services.

Through a contract between the Division and the Arizona Health Care Cost Containment System and through an Intergovernmental Agreement between the Division and the Arizona Department of Health Services/Division of Behavioral Health Services, the Division shall utilize the Regional Behavioral Health Authorities and their provider networks for the delivery of behavioral health services.

1403.2 Definitions

Accessible Behavioral Health Service

A behavioral health or substance abuse service which can be obtained by a Long Term Care eligible person within the time frames of behavioral health standards established by the Arizona Health Care Cost Containment System, the Arizona Department of Health Services/Division of Behavioral Health Services, the Division, federal law, state statute and rules, and any subsequent amendments thereto.

Arizona Department of Health Services/Division of Behavioral Health Services Behavioral Health Policy Manual

The Arizona Department of Health Services/Division of Behavioral Health Services Behavioral Health Policy Manual documents the program policies, roles and responsibilities of the Arizona Department of Health Services/Division of Behavioral Health Services and their subcontracted Regional Behavioral Health Authorities for delivery of behavioral health services to eligible Long Term Care System members.

Administration Standards

The standards established by the Arizona Health Care Cost Containment System, the Arizona Department of Health Services/Division of Behavioral Health Services Behavioral Health Policy Manual, the Arizona Health Care Cost Containment System Medical Policy Manual, the Medicaid State Plan, the Arizona Health Care Cost Containment System claims processing and provider registration requirements, federal and state statutes, rules, and subsequent amendments thereto.

The Arizona Health Care Cost Containment System Medical Policy Manual

The Arizona Health Care Cost Containment System Medical Policy Manual documents the medical and program policies and requirements implemented by the Arizona Health Care Cost Containment System Administration for health plans, program contractors and fee-for-service providers of covered services. The Manual provides information regarding covered health care services for all eligible the Arizona Health Care Cost Containment System members, long term care services covered through Long Term Care System for eligible people who are elderly or have a physical disability and members with developmental disabilities. It also provides behavioral health information relevant to the Long Term Care System.

Arizona Level of Functioning Assessment. A tool used to assist in assessing functional level.

Arizona Long Term Care System

Arizona Long Term Care System authorized under Arizona Revised Statutes § 36-2931 et seq. to provide Title XIX services to Division eligible persons with developmental disabilities.

Alternative Residential Care Facility, a facility licensed by the Department of Health Services with 16 or fewer beds and outside an eligible person's home. Alternative Residential Care Facilities include crisis stabilization facilities, psychiatric health facilities, residential detoxification facilities, therapeutic foster homes, and therapeutic group homes.

In addition to being licensed as an appropriate behavioral health residential setting, Alternative Residential Care Facilities may be licensed by the Department of Health Services as qualified behavioral health settings for designated services in Appendix 1400.G of this Manual. Behavioral health services provided by Alternative Residential Care Facility providers are dependent on the type of facility providing the service and the behavioral health needs of the eligible person. Appendix

1400.G identifies behavioral health services that may be provided in or by these facilities. Room and board is not an Long Term Care System covered service in Alternative Residential Care Facilities.

Arizona Department of Health Services

The state department mandated to serve the public health needs including the behavioral health needs of all Arizona residents.

Behavioral Health Coordinator

A Division employee, in conjunction with the Division Support Coordinators, who is responsible for coordinating treatment recommendations of the Division Medical Director/Consulting Psychiatrist, facilitating communication and problem resolution between local District Division staff or Support Coordinators and appropriate Regional Behavioral Health Authority staff or behavioral health providers, attending and participating in local behavioral health groups (including coordinating councils), developing and writing policy and procedures for behavioral health services delivery, providing training regarding Long Term Care System behavioral health services, developing and clarifying quality management activities which will ensure continuity of care for Long Term Care System eligible individuals needing behavioral health services, and serving as a resource for the Division with questions concerning behavioral health for Long Term Care System eligible individuals.

Behavioral Health Liaison Committee

Established by the Division Assistant Director in October 1990, comprised of personnel from each district and from the Behavioral Health Unit of Managed Care Operations, this committee provides input to the Division "from the field" regarding implementation of behavioral health service~~s~~ delivery systems. The committee provides a forum for discussion of behavioral health issues and questions, addresses changes in behavioral health policies and programs, and

targets resolutions currently needed to provide continuity of care for Long Term Care System eligible individuals who require behavioral health services.

Behavioral Health Liaison Committee Member

Each District Program Administrator or District Program Manager will identify one person from each District to serve as the District's Behavioral Health Liaison Member. It is the responsibility of this person to act as the behavioral health contact person for the District and to present quality of care and behavioral health system issues at the liaison

meetings. It is also this person's responsibility to participate in behavioral health quality management activities.

Behavioral Health Provider/Behavioral Health Professional

The organization and/or behavioral health professionals qualified in accordance with Behavioral Health Standards, including appropriate licensure and/or certification. A Behavioral Health Provider must maintain a contract with the referring Regional Behavioral Health Authority and, if reimbursed by Title XIX funds, must also be registered with the Arizona Health Care Cost Containment System to provide the specific behavioral health services being delivered.

Behavioral Health Services

Those Long Term Care System covered services that may be reimbursed with funds for behavioral health or substance abuse disorders when the services are medically necessary; are developed through either a Regional Behavioral Health Authority, the Arizona Health Care Cost Containment System Health Plan or Long Term Care System Program Contractor; are contained in the approved individual service plan, when required; are approved through the prior authorization process, if appropriate and designated in Appendix 1400.G of this Manual; and meet the requirements set forth in the Arizona Department of Health Services/Division of Behavioral Health Services Behavioral Health Policy Manual and the Arizona Health Care Cost Containment System Medical Policy Manual.

Behavioral Health Standards

The standards established by the Arizona Health Care Cost Containment System, Arizona Department of Health Services/Division of Behavioral Health Services, the Division, federal law, state statute, rules and any subsequent amendments thereto. At a minimum, these standards shall include the Arizona Department of Health Services/Division of Behavioral Health Services Behavioral Health Policy Manual and the Arizona Department of Health Services Quality Management Plan.

Collaboration

The process by which Support Coordinators work cooperatively with the individual, their family or guardian, the Behavioral Health Professional or designee and anyone else the individual, their family or guardian choose to include in the process in order to ensure that the best possible plan is developed and implemented for individuals and families.

Continued Stay Review

Process required to determine the medical necessity and appropriateness of continuation of an eligible individual's stay at an inpatient level of care.

Court-ordered Evaluation

An evaluation ordered by the court under Arizona Revised Statutes § 36-501, et seq. for the purpose of determining the need for behavioral health treatment.

Court-ordered Treatment

Behavioral health treatment ordered by the court under Arizona Revised Statutes § 36-501, et seq.

Crisis Stabilization Facility

An Alternative Residential Care Facility, licensed as a Level II or Level III behavioral health agency, with 16 or fewer treatment beds, which provides 24-hour supervision of eligible persons who require a protected, supervised environment to reduce or eliminate an emergency situation. Room and board is not a Long Term Care System covered service in this facility.

Division Individual Support Plan Team

Individuals directly involved in the provision of services to an eligible person/family. At a minimum, the Individual Support Plan Team will include, but not be limited to, the individual; the individual's parent or guardian, if any; the Division Support Coordinator, who shall serve as plan facilitator and coordinator; representatives, including Regional Behavioral Health Authority personnel, of any service being provided or indicated by assessment to be needed; and any additional person(s), approved by the individual/responsible person, whose participation is necessary to develop a complete and effective plan. This team is also known as the Interdisciplinary Team.

Division Support Coordinator

Formerly referred to as the Division Case Manager, as defined in Arizona Revised Statutes § 36-551, means a person employed by or contracted with the Division to provide Support Coordination (formerly referred to as Case Management) under the requirements of the Long Term Care System program to Division eligible persons with developmental disabilities. The Division Support Coordinator is the Division's Long Term Care System eligible person's primary case

manager and shall have the responsibility for participating in the behavioral health service planning process.

DSM

The latest edition of the "Diagnostic and Statistical Manual of Mental Disorders" edited by the American Psychiatric Association.

Eligible Individual

An individual of any age, who is eligible under Long Term Care System categories of reimbursement (see Arizona Revised Statutes § 36-2931.5.), including amendments to Long Term Care System eligibility categories, enrolled with the Division.

Emergency Behavioral Health Services

Emergency/crisis behavioral health services are covered services, available on a 24-hour basis, which are provided after the sudden onset of a behavioral health or substance abuse condition, manifesting itself by acute symptoms of sufficient severity, when the absence of immediate medical attention could result in placing the Division Long Term Care System eligible individual's health in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or serious behavioral dysfunction to indicate the person is a danger to self or others.

Evaluation

The assessment of the eligible person's psychiatric, psychological and social conditions to determine if a mental disorder exists and, if so, to provide diagnosis for the direction of care.

Grievance and Appeal

A process whereby a complaint can be filed regarding an act, omission or condition, as provided in the Arizona Department of Health Services Grievance and Appeal Process for Persons eligible under the Serious Mental Illness program, or Children, or General Mental Health and Substance Abuse programs under Title XIX/XXI or Subvention funded services.

Group and/or Family Therapy

An interaction between/among the behavioral health professional or behavioral health technician, under the supervision of a behavioral health professional, the eligible individual and his/her family and/or

spouse or other group, that addresses the therapeutic goals as outlined in the individual service plan.

Human Rights Advocate

The human rights advocates appointed by the director of Arizona Department of Health Services under Arizona Administrative Code R9-21-105.

Individual Service Plan/Treatment Plan (Regional Behavioral Health Authority Individual Service Plan)

A specific plan of treatment developed by the Regional Behavioral Health Authority or Regional Behavioral Health Authority provider, as an Individual Service Plan team member, with the participation of the Division Support Coordinator, for each the Division Eligible Individual that specifies behavioral health services, treatment goals, service units, anticipated time frames, and identified provider(s) of care. The Regional Behavioral Health Authority Individual Service Plan is to be incorporated into the eligible person's Division Individual Support Plan by the Division Support Coordinator.

Individual Support Plan

The written document, developed by a Division Individual Support Plan Team (Interdisciplinary Team, including Regional Behavioral Health Authority/Regional Behavioral Health Authority provider personnel), defining needed services to be provided and goals and objectives to be attained for a person with developmental disabilities.

The Division Individual Support Plan directs the provision of safe, secure, and dependable active services in areas that are necessary for individuals to achieve full social inclusion, independence, and personal and economic well being.

Individual Therapy

A face-to-face interaction between a behavioral health professional or behavioral health technician, under the supervision of a behavioral health professional, and the eligible individual that addresses the therapeutic goals as outlined in the Individual Service Plan.

Intergovernmental Agreement

An agreement between the Division and Arizona Department of Health Services/Division of Behavioral Health Services whereby the latter contracts with Regional Behavioral Health Authorities for the provision

and management of behavioral health services for the Division Long Term Care System eligible individuals.

Joint Commission on Accreditation of Healthcare Organizations.

Levels of Care

Acute inpatient hospital (including psychiatric health facilities, as well as general and specialty hospitals that provide short-term acute inpatient care with daily psychiatric supervision and 24-hour nursing); Joint Commission on Accreditation of Healthcare Organizations accredited residential treatment center for individuals under 21 years of age; and outpatient services.

Long-term View

A planning statement that identifies, from the individual's perspective, what the individual would like to be doing for work, education, and leisure, including where the individual would like to be living for up to a three-year period with projected timeframes for achievement. The long-term view is based on the person's unique interests, strengths, and personal desires.

Mechanical Restraint

The use of any mechanical device to restrict the movement or normal function of a portion of the individual's body, excluding only those devices necessary to provide support for the achievement of functional body position or proper balance.

Medical Record

A single, complete record kept by the eligible individual's primary care physician who documents the medical, behavioral health and substance abuse services received by the eligible individual. Records pertinent to behavioral health and substance abuse services are summarized by the Regional Behavioral Health Authority or its designee and sent to the Primary Care Physician as notification of services provided to the eligible person.

Mobile Crisis Unit

One or more individuals who provide(s) emergency/crisis behavioral health services under the authority of a licensed behavioral health service agency. At least one member of the unit shall be a behavioral health professional pursuant to Arizona Administrative Code R9-20-306 (B).

Medically Necessary Behavioral Health Covered Services

Those services that are provided by practitioners within the scope of their practice to prevent disease, disability, and/or other adverse health conditions or their progression, and to promote progress towards the highest possible level of health and self-sufficiency; are reasonably expected to benefit the eligible person's behavioral or physical health; are necessary and appropriate to the eligible person's present condition; and are designed to assist eligible and enrolled persons to manage their illness to the extent possible to live, learn, and work in their own communities.

Multidisciplinary Team

The clinical/interdisciplinary team of persons who are responsible for providing continuous treatment and support to an eligible person and for locating, accessing and monitoring the provision of behavioral health services. This team may consist of the individual and their family or guardian, psychiatrist, Regional Behavioral Health Authority case manager, vocational specialist, psychiatric nurse, and other professionals or paraprofessionals, such as a psychologist, social worker, therapist, consumer case management aide, or rehabilitation specialist, as needed, based on the consumer's needs. The team shall include a Qualified Behavioral Health Professional.

Primary Behavioral Health Professional

A Primary Behavioral Health Professional is a person who is responsible for the overall direction and coordination of care of an eligible person who is receiving behavioral health services through a Regional Behavioral Health Authority or Regional Behavioral Health Authority Provider. A Primary Behavioral Health Professional is responsible for the overall behavioral health direction of a person. Whereas, a Qualified Behavioral health Professional is a person who can provide a medically necessary behavioral health service. Refer to the definition of a Qualified Behavioral Health Professional to ascertain who can provide a behavioral health service and be reimbursed by Medicaid funds.

Petition for Court-ordered Evaluation

A procedure authorized under Arizona Revised Statutes §36-521 wherein a Regional Behavioral Health Authority, in consultation with an individual's clinical team shall prepare and file with the court Arizona Department of Health Services Form MH-105 petitioning the court to order an involuntary evaluation. Whenever possible, the Regional Behavioral Health Authority shall conduct pre-petition screening.

Arizona Administrative Code R9-21-502.

Petition for Court-ordered Treatment

Upon a determination that an individual is a danger to self or others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the medical director of the agency having provided the court-ordered evaluation shall file, with appropriate affidavits, a petition for court-ordered treatment for an individual alleged to be gravely disabled, a danger to self or others, and/or persistently or acutely disabled. The individual's clinical/multidisciplinary team shall be consulted prior to filing the petition.

Arizona Administrative Code R9-21-505.

Pharmacological Restraint

The use of a psychopharmacological drug for discipline of the person or convenience of the staff and not solely required to treat medical symptoms identified by staff and recorded in the person's medical record:

a. in response to a likelihood of serious harm; or

b. in such a manner as to unreasonably restrict a client's movement.

A physician's order for pharmacological restraint shall be limited to the dosage necessary to achieve its effect (Arizona Administrative Code R9-21-204) in assisting the person to regain control of behaviors that pose a likelihood of serious physical harm as defined in Arizona Administrative Code R9-21-101.

Physical Restraint

The use of bodily force to restrict the individual's freedom of movement, excluding the firm, yet gentle holding of a person for less than five minutes with no more force than necessary to protect the individual or others from harm.

Positive Behavior Support

Positive Behavior Support is an approach to helping individuals improve their challenging behavior based upon the understanding that people do not control others, but seek to support others in their own behavior change process and a belief that there is a reason behind most challenging behavior and that people with challenging behavior should be treated with compassion and respect.

Primary Support Coordinator

The Division Support Coordinator is the lead Case Manager for eligible individuals with medical, long-term care and behavioral health needs. Upon enrollment for behavioral health services, an eligible individual may be assigned a Regional Behavioral Health Authority case manager or certified behavioral health professional to address behavioral health needs, however, the Division Support Coordinator retains primary responsibility for the collaboration and oversight of service delivery.

Prior Authorization

The process by which the appropriate entity (Regional Behavioral Health Authority, the Arizona Health Care Cost Containment System Health Plan, or Long Term Care System Program Contractor) reviews and authorizes for Title XIX reimbursement, the initiation of certain behavioral health services, including medically necessary transportation and inpatient services.

PRN Order or "Pro re nata" Medication

Unscheduled medications given on an as-needed basis under a physician's orders.

Provider

An organization and/or behavioral health professional appropriately certified/licensed and registered with the Arizona Health Care Cost Containment System and contracted with a Regional Behavioral Health Authority to provide behavioral health services.

Psychiatric Health Facility

An Alternative Residential Care Facility, which may also be a Crisis/Secure Residential Facility, licensed by the Department of Health Services as a Level I behavioral health facility in accordance with Arizona Administrative Code R9-10-5040, with 16 or fewer treatment beds. This facility provides services to an eligible individual with an acute psychiatric or mental disorder or one who needs stabilization of a chronic mental illness. Appendix 1400.G of this Manual identifies covered services that may be provided in a Psychiatric Health Facility.

Psychiatric Urgent Care Center

Site for crisis care providing crisis screening and triage, crisis assessment and psychiatric evaluation, crisis intervention and medication, seclusion and restraint, and court-ordered evaluation, to stabilize a situation and ensure safety within a 23 hour period when

children, adolescents, families or adults are experiencing acute emotional distress that may pose an immediate threat to life and functioning.

Psychotropic Medication Adjustment and Monitoring

A covered behavioral health service which includes prescriptions for psychotropic medications, review of the effects and side effects, and adjustment of the type and dosage of psychotropic medications prescribed that address the therapeutic goals outlined in the Individual Service Plan. Laboratory testing and behavioral observation are essential components of this service.

Qualified Behavioral Health Professional

Staff who meet one of the following qualifications as defined in Arizona Administrative Code R9-20-306:

a. Licensed Psychiatrist;

b. Licensed Psychologist;

c. Certified Social Worker (State or National Certification);

d. Certified Counselor (State or National Certification);

e. Licensed Nurse Practitioner (Arizona Board of Nursing);

f. Licensed Physician Assistant (Arizona Board of Medical Examiners); or

g. Licensed Registered Nurse (Arizona Board of Nursing) with one year of work experience in behavioral health.

Qualified Behavioral Health Professional or Primary Behavioral Health Professional Initial and Quarterly Consultation

A telephonic or face-to-face conversation, or a mutual exchange and review of written information between a Division Support Coordinator and a Qualified Behavioral Health Professional or Primary Behavioral Health Professional regarding the behavioral health needs, services, medication regime and side effects, symptoms, and progress of an eligible person who is receiving behavioral health services through a Regional Behavioral Health Authority or Regional Behavioral Health Authority Provider.

Quality Management Plan

The document which outlines the Quality Management Structure that will be utilized for behavioral health services. The Quality Management Plan includes guidelines for Quality Management and Improvement, Program Requirements, Utilization Management, and Finance and Operations.

Regional Behavioral Health Authority

An organization under contract with Arizona Department of Health Services/Division of Behavioral Health Services to implement, maintain, monitor and coordinate the delivery of behavioral health services in a geographically specific service area of the state for certain eligible persons. Regional Behavioral Health Authorities may subcontract with other agencies to provide all or part of the services for which they are responsible. In this policy when referral is made to Regional Behavioral Health Authority staff this applies both to those who work for the Health Authority directly and those who work for subcontracted provider agencies.

Regional Behavioral Health Authority Case Management

Case Management in the behavioral health system is a supportive service provided to enhance treatment compliance and effectiveness.

Referral

The process of applying for behavioral health services. Individuals and families can apply directly to the Regional Behavioral Health Authority or contracted agency or seek the assistance of their Support Coordinator.

Residential Detoxification Facility

A facility licensed by Arizona Department of Health Services as a Level I behavioral health facility (inpatient hospital or Residential Treatment Center with 16 or fewer treatment beds), which provides 24-hour supervision and treatment services to systematically reduce physical dependence upon alcohol, cocaine, heroin, methadone, prescription drugs and other drugs through the use of therapeutic procedures, medications, rest, diet, counseling and medical supervision. Appendix 1400.G of this Manual identifies covered services that may be provided in this facility.

Residential Treatment Center

An inpatient psychiatric facility for persons under the age of 21, accredited by Joint Commission on Accreditation of Healthcare Organizations, and licensed by the Arizona Department of Health Services as a residential treatment center pursuant to Arizona Administrative Code R9-10-5041.

Screening

An in-person interaction with the eligible individual to determine the need for behavioral health services and the assignment of the eligible person for further evaluation, care, and treatment

Seclusion

Restricting an individual to a room or area through the use of locked doors or any other device or method which precludes a person from freely exiting the room or area, including when a person reasonably believes his/her exit is restricted. In the case of an inpatient facility, confining a person to the facility, the grounds of the facility, or a ward of the facility, does not constitute seclusion. In the case of a community residence, restricting a person to the residential site, pursuant to specific provisions of an individual service/support plan or court order, does not constitute seclusion.

Seriously Mentally Ill

Is a behavioral health eligibility category for persons, who as a result of a mental disorder in which persons age 18 and over, exhibits emotional or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these eligible persons, mental health disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation.

Seriously Mentally Ill Checklist

Arizona Department of Health Services/Division of Behavioral Health Services Checklist containing criteria for determination of a person's eligibility for the Seriously Mentally Ill program. Like categorical Medicaid eligibility, Seriously Mentally Ill is an entitlement status, not a mental or medical condition.

Single Purchase of Care

One of nine initiatives identified in the Intergovernmental Agreement among Arizona Department of Health Services, Department of Economic Security, Arizona Department of Education, Arizona Department of Juvenile Corrections, and Arizona Office of the Courts to "... improve the children's behavioral health delivery system." The purpose of the Single Purchase of Care process is to coordinate the efforts of all the State Agencies and Regional Behavioral Health Authorities, which purchase behavioral health services for children. It is an attempt to eliminate duplication of contracting processes, to coordinate development of comprehensive provider networks, and to develop a single definition for each type of service purchased.

State Protection and Advocacy System

The agency designated as the Protection and Advocacy System for individuals with mental illness, pursuant to 42 United States Code 10801-51.

Substance Abuse

Chronic, habitual or compulsive use of any chemical matter, which, when introduced into the body, is capable of altering human behavior or altering behavioral functioning, and which with extended use may cause psychological or physiological dependence and/or impaired behavioral, social or educational functioning. For purposes of the Long Term Care System behavioral health program, nicotine addiction is not considered substance abuse.

Therapeutic Foster Home

An Alternative Residential Care Facility licensed by the Department of Economic Security (with Arizona Department of Health Services endorsement to ensure Long Term Care System standards are met) as a behavioral health facility which provides a program of planned activities and individualized treatment within a structured 24-hour family-oriented setting, limited to no more than five (5) eligible children. Appendix 1400.G identifies covered services that may be provided in a Therapeutic Foster Home. Room and board is not an Long Term Care System covered service in this facility.

Therapeutic Group Home

An Alternative Residential Care Facility, licensed by Arizona Department of Health Services as a Level II or Level III behavioral health facility, with 16 or fewer treatment beds and 24-hour supervision. Appendix 1400.G identifies covered services that may be provided in a Therapeutic Group

Home. Room and board is not a Long Term Care System covered service in this facility.

Third Party

Any individual, entity or program that is liable or may be liable to pay all or part of the medical or behavioral health expenses incurred by an eligible individual. Third parties include, but are not limited to, private health insurance, employment-related health insurance, medical support from absent parents, automobile insurance, court judgments or settlements from a liability insurer, state workers' compensation, long-term care insurance and other federal programs.

Third Party Liability

Third Party Liability is the resources available from a person, entity or program that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical or behavioral health expenses incurred by an eligible individual.

1403.3 Covered Behavioral Health Services

Covered behavioral health services for Long Term Care System eligible persons are listed in Appendix 1400.G of this Manual. Long Term Care System covered behavioral health services, in all instances, shall be provided by qualified providers meeting Department of Health Services, state licensure and certification requirements, or national certification requirements, who are registered with the Arizona Health Care Cost Containment System.

Services provided must be medically necessary, meaning the service is reasonably expected to benefit the individual's mental or physical health and there is no equally effective service that is less restrictive or substantially less costly. Services shall be appropriately authorized in accordance with the Individual Support Plan/Treatment Plan developed for the eligible person.

Behavioral health professionals (except psychiatrists and psychologists), behavioral health technicians and other qualified staff meeting state licensure and certification requirements shall be affiliated with an alternative residential care facility, clinic, outpatient hospital or rehabilitation agency. Only psychiatrists and psychologists may bill independently for services provided, unless special provision has been made to directly contract, outside of the Regional Behavioral Health Authority network or providing agency, for a specialized or individualized service. Alternative residential care facilities, clinics, outpatient hospitals or rehabilitation agencies must bill for services provided by other behavioral health professionals, i.e., social workers, counselors, registered nurse practitioners, registered nurses or physician's assistants. Providers shall not charge, submit a claim, demand or

otherwise collect payment from an eligible person (or person acting on behalf of an eligible person).

1403.4 Referral and Evaluation Process

Referral

The individual or his/her designee can apply directly to the Behavioral Health Authority or it's contracted agencies, or seek the assistance of the Division Support Coordinator. If the assistance of the Support Coordinator is requested The Individual Support Plan Team shall rule out medical, neurological, and environmental causes for changes in behavior and shall determine if a referral is appropriate and what behavioral health services are requested. The Support Coordinator shall then initiate a referral for behavioral health services with the permission of the eligible individual, guardian, or responsible party according to Arizona Department of Health Services/Division of Behavioral Health Services policy and the Division District procedure. Refer to Appendix 1400.K for a pre-referral checklist.

Evaluation

The Regional Behavioral Health Authority is responsible for providing screening and evaluation services in accordance with behavioral health standards and within required time frames. The evaluation shall include a determination of diagnosis.

a. for emergency referrals, the Regional Behavioral Health Authority shall arrange and provide a screening and preliminary evaluation decision within twenty-four (24) hours of the emergency referral;

b. for non-emergency referrals, the Regional Behavioral Health Authority shall arrange and provide a screening of the individual within seven (7) days of the referral. The evaluation process must be completed; the Individual Service Plan developed, and authorized medically necessary behavioral health services commenced within thirty (30) days from the date of the initial screening;

c. the Division Support Coordinators are responsible for providing the Division case record documentation within five (5) working days of the Regional Behavioral Health Authority's request or at intake and within one (1) working day of an emergency intake;

d. the Division Support Coordinator and/or person(s) who has (have) knowledge of the eligible individual's situation and behavioral health needs shall participate in the Regional Behavioral Health Authority screening and evaluation process, and shall attend the screening and evaluation sessions, unless other arrangements have been made in

advance and agreed upon by the Regional Behavioral Health Authority and the Division; and

e. to determine who bears signatory authority to sign Regional Behavioral Health Authority documents, including Consents to Treatment, Individual Service Plans, and Consents for Disclosure of Information, see SIGNATORY AUTHORITY in Appendix 1400.L.

1403.5 Support Coordination/Case Management

State and federal laws designate the Division as the agency having primary responsibility for case management of persons with developmental disabilities. The Division Support Coordinator shall collaborate with the Regional Behavioral Health Authority Behavioral Health Professional or designee to integrate medically necessary behavioral health services into the Division Individual Support Plan/Regional Behavioral Health Authority Individual Service Plan.

a. an initial and quarterly consultation between a Support Coordinator and a Regional Behavioral Health Authority Qualified Behavioral Health Professional or Primary Behavioral Health Professional is required for the Division Long Term Care System eligible individuals, in those cases where the Division Support Coordinator does not meet the qualifications of a Qualified Behavioral Health Professional .

1. an initial consultation with a Regional Behavioral Health Authority Qualified Behavioral Health Professional or Primary Behavioral Health Professional will be conducted by the Division Support Coordinator on every Division Long Term Care System eligible individual entering the Behavioral Health System

2. a quarterly consultation with a Regional Behavioral Health Authority Qualified Behavioral Health Professional or Primary Behavioral Health Professional by the Division Support Coordinator must occur on every Division Long Term Care System eligible individual who receives services from the Behavioral Health System.

3. as part of the consultation with a Qualified Behavioral Health Professional or Primary Behavioral Health Professional, the Division Support Coordinator must document the Division Long Term Care System eligible individual's behavioral health needs, services, medication regime and side effects,

symptoms, and progress, as well as the credentials of the Qualified Behavioral Health Professional or Primary Behavioral Health Professional. A copy of the Support Coordinator's service plan review will be sent to the Regional Behavioral Health Authority Behavioral Health Professional or designee; and

4. a standardized form has been developed to facilitate the Qualified Behavioral Health Professional or Primary Behavioral Health Professional consult requirement when a the Division Support Coordinator is unable to attend a behavioral health staffing or medication review. Refer to Appendix 1400.M.

b. the Division Support Coordinator Supervisor shall notify the appropriate Regional Behavioral Health Authority Behavioral Health Professional or designee of any changes in the Division Support Coordinator assignments within five (5) working days of the assignment or change in assignment;

c. the Division Support Coordinator shall ensure that the Regional Behavioral Health Authority Behavioral Health Professional or designee is notified within one working day of significant changes in the eligible individual's circumstances or other significant events, which shall include but not be limited to unusual incidents required to be reported per the Division policy. The Division Support Coordinator shall collaborate with the Regional Behavioral Health Authority Behavioral Health Professional or designee in facilitating any changes in the Division Individual Support Plan/Regional Behavioral Health Authority Individual Service Plan, which are necessary due to a significant change in circumstance or other significant event;

d. the Division Support Coordinator shall provide information requested by the Regional Behavioral Health Authority Behavioral Health Professional or designee, and document this communication, during transition of a the Division Long Term Care System eligible individual between Regional Behavioral Health Authorities or between Regional Behavioral Health Authority providers, due to change of residence, or for provider availability, and in the transition of an eligible individual from the children's to the adults' behavioral health service delivery system;

e. for the Division foster care persons, (refer to SIGNATORY AUTHORITY, Appendix 1400.L of the Division Policy Manual to determine who bears signatory authority to sign Regional Behavioral Health Authority documents), the Division Support Coordinator shall:

1. notify the Regional Behavioral Health Authority Behavioral Health Professional or designee of any report and review hearings, other scheduled hearings regarding the eligible individual, and of Foster Care Review Board hearings at least two (2) weeks prior to the hearing. In cases when a court hearing is scheduled or rescheduled on short notice, the Division Support Coordinator shall notify the Regional Behavioral Health Authority Behavioral Health Professional or designee as quickly as possible prior to the hearing date;

2. request additional reports for Court and Foster Care Review Board purposes from the Regional Behavioral Health Authority Behavioral Health Professional or designee at least two (2) weeks prior to the date the report is needed;

3. when the Regional Behavioral Health Authority Behavioral Health Professional or designee cannot attend a court hearing /review, the Division Support Coordinator shall share the Regional Behavioral Health Authority's or designee's recommendations for continued clinical services with the court. The Division Support Coordinator shall inform the Regional Behavioral Health Authority Behavioral Health Professional or designee of any additional recommendations or requests that result from the court hearing/review within two (2) working days.

f. individuals with attention deficit disorder/attention deficit-hyperactivity disorder, uncomplicated depressive disorders and anxiety disorders can obtain psychotropic medications from their Arizona Long Term Care primary care physician. If a primary care physician feels that a person's care is too complex, he or she refers the individual to The Regional Behavioral Health Authority. The primary care physician can also seek consultation from a Regional Behavioral Health Authority psychiatrist. .Individuals may receive other behavioral health services from the Regional Behavioral Health Authority while receiving medication management from their primary care physician.

g. when an individual receives medication management from the Regional Behavioral Health Authority, the Support Coordinator is responsible for ensuring that the Arizona Long Term Care primary care physician is informed about the care provided by the Regional Behavioral Health Authority.

1403.6 Treatment Planning

Please read Chapter 800 of this Manual (Plan Development) for detailed information about plan development. The operating principles in Section 804 of this Manual require plans to be centered upon strengths, resources and needs of the individual served and apply equally when collaborating with the Behavioral Health System. When teams look at changing challenging behavior a positive behavior support approach will be followed. Division District personnel and their respective Regional Behavioral Health Authority/Regional Behavioral Health Authority's designee shall develop procedures for collaborating in the development and revisions of a consolidated service plan for the Division Long Term Care System eligible individuals.

Note: the Arizona Health Care Cost Containment System Title XIX, non-Long Term Care System eligible individuals, otherwise known as Targeted Support Coordination, are an entitlement group within the behavioral health system and qualify for the same behavioral health services as the Division Long Term Care System eligible individuals. Refer to Appendix 1400.G for a list of covered services.

a. minimum requirements for treatment planning:

1. the Division Support Coordinator shall participate in the Regional Behavioral Health Authority Individual Service Plan process and/or review and sign the Regional Behavioral Health Authority Individual Service Plan to indicate that the Division Support Coordinator has participated in the process. The Division Support Coordinator shall indicate agreement or disagreement with all or part of the Regional Behavioral Health Authority Individual Service Plan and shall incorporate the Regional Behavioral Health Authority Individual Service Plan into the Division Individual Support Plan. The Regional Behavioral Health Authority Behavioral Health Professional or designee shall be encouraged to participate in the Division Individual Support Plan meeting and/or review. Participation may be telephonic;

2. the Division Support Coordinator shall encourage the participation of the eligible individual, the eligible individual's parent(s), legal guardian, foster parent(s), or others involved with the eligible individual's care in treatment staffings and the Individual Service Plan development process through notification of meeting times and places. Participation may be telephonic. If transportation to the meeting is needed by the individual or family the Support Coordinator will assist with coordinating transportation.

3. the Regional Behavioral Health Authority or designee shall provide a copy of the approved Regional Behavioral Health Authority Individual Service Plan, including documentation of medications and authorized behavioral health services, to the Division Support Coordinator within five (5) working days of completion of the Individual Service Plan meeting. The Division Support Coordinator shall enter the information regarding behavioral health services into the Arizona Social Services Information and Statistical Tracking System. Refer to Appendix 1400.O for a list of and description of the "A" through "F" behavior health codes;

4. the Division Support Coordinator shall provide a copy of the Division Individual Support Plan to the Regional Behavioral Health Authority Behavioral Health Professional or designee;

5. reviews of behavioral health services occur every ninety (90) days **OR** every 180 days for those individuals who are not diagnosed as Seriously Mentally Ill by the Regional Behavioral Health Authority or designee and reside in a Division funded residential placement. More frequent reviews may occur based on an individual's progress or lack thereof.

b. the following approach is suggested for those individuals who require a high level of collaboration:

1. the Division Support Coordinator and the Regional Behavioral Health Authority Behavioral Health Professional or designee shall co-facilitate the combined Division Individual Support Plan/Regional Behavioral Health Authority Individual Service Plan meeting. This meeting shall fulfill the requirements of both the Division Individual Support Plan process and the Regional Behavioral Health Authority Individual Service Plan process. Each area will address how disagreements will be documented on the combined Division Individual Support Plan/Regional Behavioral Health Authority Individual Service Plan;

a. the following shall occur prior to the combined Division Individual Support Plan/Regional Behavioral Health Authority Individual Service Plan meeting:

1. the Division Support Coordinator, after consultation with the individual and/or their family or guardian coordinates the date for the meeting with the Regional Behavioral Health Authority Behavioral Health Professional or designee. Copies of professional assessments are exchanged between the Division Support Coordinator and the Regional Behavioral Health Authority Behavioral Health Professional or designee; and

2. notification shall be sent to all parties ten days prior to the scheduled meeting. The Division Support Coordinator shall review the case, prior to the meeting, with any relevant party who is unable to attend the meeting and will review the plan with the person after the meeting;

b. the combined Division Individual Support Plan/Regional Behavioral Health Authority Individual Service Plan meeting shall address the following components which shall be documented on required Division and Regional Behavioral Health Authority forms by the Division Support Coordinator and the Regional Behavioral Health Authority Behavioral Health Professional or designee.

1. assessment information from the Division and the Regional Behavioral Health Authority shall be reviewed;

2. in conjunction with other team members, the Division Support Coordinator shall assist the Division Long Term Care System eligible individual and/or guardian with developing his/her long-term view/vision of the future. For Seriously Mentally Ill individuals this is stated in terms of where the person will live, what the person will do during the day, and leisure activities over the next one to three years;

2. assessment of the eligible individual's strengths and resources, including those services necessary to support movement toward his/her

long-term view/vision of the future, shall be discussed;

4. establishment of Goals, Objectives, and Methodologies; and

5. signatures of all team members on required forms.

c. the following activities shall occur after the combined Division Individual Support Plan/Regional Behavioral Health Authority Individual Service Plan meeting.

1. copies of the Division Individual Support Plan and the Regional Behavioral Health Authority Individual Service Plan (including authorized services and medications) shall be exchanged between the Division Support Coordinator and the Regional Behavioral Health Authority Behavioral Health Professional or designee;

2. the Division Support Coordinator shall enter the appropriate "A" through "F" behavioral health codes (Appendix 1400.G) into the Arizona Social Services Information and Statistical Tracking System; and

6. reviews of behavioral health services occur every ninety (90) days **OR** every 180 days for those individuals who are not diagnosed seriously mentally ill by the Regional Behavioral Health Authority who live in a Division funded residential placement. More frequent reviews may occur based on an individual's progress or lack thereof.

1403.7 Certification and Recertification of Need for Inpatient Psychiatric Services

a. the Regional Behavioral Health Authority Medical Director or designee, Multi Disciplinary Team, or the facility team that develops the plan of care, to comply

with federal requirement for treatment in an inpatient psychiatric facility or an inpatient hospital for Long Term Care System eligible persons under the age of 21 years, Joint Commission on Accreditation of Healthcare Organizations, accredited Residential Treatment Center shall complete a Certificate of Need.

1. for an individual who is a Medicaid recipient when admitted to a facility or program, certification that inpatient services are needed must be made by an independent team that includes a physician; and

2. for an individual who applies for Medicaid while in the facility or program, certification that inpatient services are needed must be made by the team responsible for the plan of care. (See Recertification of need for care below).

b. recertification of Need for Care in inpatient hospitals shall be completed by a physician, a physician assistant or nurse practitioner at least every 60 days after certification. A physician and other personnel involved in the care of the individual must establish a written plan of care for each recipient. A physician and other personnel involved in the recipient's care must review each plan of care at least every 60 days;

c. recertification of Need for Care in mental hospitals shall be completed by a physician, a physician assistant or nurse practitioner recertifying that inpatient services are needed at least every 60 days after certification. A physician and other personnel involved in the care of the individual must establish a written plan of care for each recipient. A physician and other personnel involved in the recipient's case must review each plan of care at least every 90 days;

d. for Certification of Need for Care, the individual plan of care must be developed and implemented no later than 14 days after admission by an interdisciplinary team of physicians and other personnel (including a Board-eligible or Board-certified psychiatrist, a clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy or physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association, and either a psychiatric social worker, a registered nurse with specialized training or one year's experience in treating mentally ill individuals, and an occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating

mentally ill individuals, or a psychologist who has a master's degree in clinical psychology or who has been certified by the State or the State psychological association) who are employed by or provide services to patients in the facility, in consultation with the recipient; and his parents, legal guardians, or others in whose care he will be released after discharge. Each plan of care must be reviewed every 30 days by the team.

1403.8 Crisis Management and Inpatient Psychiatric Hospitalization

a. for eligible individuals who are enrolled with a Regional Behavioral Health Authority:

1. during Regional Behavioral Health Authority business hours the Division Support Coordinator may contact, as applicable, the Regional Behavioral Health Authority Behavioral Health Professional, their designee or the designated crisis system for assistance with the crisis situation. After Regional Behavioral Health Authority business hours, weekends, and holidays, contact the Regional Behavioral Health Authority designated crisis system for assistance with the crisis situation;

2. the Division Support Coordinator or designee shall provide available information regarding the individual and the crisis situation to augment the Regional Behavioral Health Authority's ability to accurately assess and appropriately intervene in the crisis situation;

3. the Regional Behavioral Health Authority shall notify the Division Support Coordinator or authorized designee, the eligible individual's Primary Care Physician and/or referral source, if different than the Primary Care Physician, of the outcome of the assessment within twenty-four (24) hours of the assessment;

4. the Regional Behavioral Health Authority shall provide behavioral health services identified through the emergency evaluation as medically necessary to reduce or eliminate the emergency/crisis situation;

5. the Division Support Coordinator or designee shall participate in implementing the crisis resolution plan developed by the Regional Behavioral Health Authority or designee and the Division after assessment of the individual and the crisis situation;

6. if it is determined through the Regional Behavioral Health Authority's assessment of the crisis situation that the eligible individual requires emergency hospitalization, the Regional Behavioral Health Authority shall select the facility where the eligible individual will be hospitalized, complete the prior authorization process, and arrange for transportation to the selected facility when there is an imminent threat of harm to the eligible individual if care is not rendered expeditiously or when other forms of non-emergency transportation (including transportation by the Division) have been explored and are unavailable;

7. the Division Support Coordinator or designee shall coordinate required signatures facilitating admission of the eligible individual to the hospital; and

8. for eligible individuals who present to an inpatient hospital in need of emergency treatment for both a medical and behavioral health related problem, the Division subcontracted health plan is responsible for authorized medical treatment and shall complete the prior authorization process while the Regional Behavioral Health Authority is responsible for completing the prior authorization process for behavioral health treatment.

b. for eligible individuals who are not enrolled with a Regional Behavioral Health Authority:

1. the Division Support Coordinator or designee shall contact the Regional Behavioral Health Authority-designated crisis system for assistance with the crisis situation;

2. the Division subcontracted health plan is responsible and at risk for, up to the first 72 hours of an emergency behavioral health inpatient psychiatric admission, not to exceed 12 days per contract year;

3. the Division subcontracted health plan shall arrange for medically necessary and/or emergency transportation to the selected facility, complete the prior authorization process, and perform utilization review and other medical management activities;

4. the Division Support Coordinator shall ensure that the appropriate Regional Behavioral Health Authority is notified of any eligible individual placed in emergency hospitalization for behavioral health reasons. This requirement may be met by the Division Support Coordinator's verification with the

hospital that a referral has been made to the Regional Behavioral Health Authority and/or designee;

5. the Regional Behavioral Health Authority or designee shall perform an assessment within twenty-four (24) hours of a referral ;

6. if it is determined through the Regional Behavioral Health Authority or designee's assessment that the eligible individual requires continuing services, the Regional Behavioral Health Authority or designee shall enroll the person and assume responsibility for provision of medically necessary behavioral health services;

7. the Division Support Coordinator shall ensure Regional Behavioral Health Authority access to appropriate Division case records and shall assist the Regional Behavioral Health Authority in obtaining access to the eligible individual and any needed medical records.

1403.9 Petitioning Process

The Regional Behavioral Health Authority shall perform, either directly or by contract, all required pre-petition screening, evaluation and treatment.

1403.10 Issue Resolution/Appeal Process

a. requests for changes in the Regional Behavioral Health Authority Individual Service Plan, including changes in the intensity of case management, level of services, or types of services, may be made by the Division Support Coordinator, the eligible individual or the eligible individual's parent, guardian or responsible party at any time. Disagreements between the Division and the Regional Behavioral Health Authority about behavioral health treatment issues or the level and types of behavioral health services provided shall be handled informally whenever possible;

b. efforts to resolve differences of opinion may include convening a staffing at the request of the Division or the Regional Behavioral Health Authority. The Division Support Coordinator or designee and the Regional Behavioral Health Authority Behavioral Health Professional or designee are responsible for participating in staffings that are convened to mediate a treatment issue. Each agency shall have persons in attendance with the authority to make decisions;

c. When the behavioral health treatment issue cannot be resolved at the District level the Division Support Coordinator may request the assistance of a Behavioral Health Coordinator in the Division Managed Care Operations. At this point, the Division Behavioral Health Coordinator shall address the issue with either the Division Medical Director/Psychiatric Consultant, Regional Behavioral Health Authority personnel or Arizona Department of Health Services/Division of Behavioral Health Services staff;

d. The Division Support Coordinator may advise the eligible individual/responsible party to initiate an appeal through the Department of Health Services/Regional Behavioral Health Authority appeals process. The person has 60 calendar days from the date of the Regional Behavioral Health Authority action to file a written appeal per Arizona Department of Health Services/Division of Behavioral Health Services Policy 2.16 (Appendix 1400.N).

1403.11 Behavioral Health Quality Management

The Regional Behavioral Health Authorities are capitated through Arizona Department of Health Services/Division of Behavioral Health Services to provide medically necessary behavioral health services for the Division/Long Term Care System eligible individuals. The Division and Arizona Department of Health Services/Division of Behavioral Health Services have developed an Operational Procedures Manual, which is a guide for the Division Support Coordinators and Regional Behavioral Health Authority Behavioral Health Professionals or designees in applying the terms of the Intergovernmental Agreement (IGA). The Manual defines procedures to coordinate behavioral health service delivery for the Division eligible individuals. Matrices with each Regional Behavioral Health Authority outline the procedure for the Division Support Coordinators in the areas of referral, evaluation, treatment planning, case management, crisis management, and treatment services mediation.

Arizona Administrative Code R6-6-901 pertains to “Managing Inappropriate Behaviors” and establishes the Division’s authority to require compliance for all programs, which are operated, licensed, supervised, or financially supported by the Division. For the Division individuals who fall under the purview of the rule and who are taking psychotropic medications, there are two independent committees (Program Review Committee and Human Rights Committee) that monitor compliance with the rule.

The Division Support Coordinator is the eligible individual’s primary case manager and shall have the responsibility for participating in the behavioral health service planning process through collaboration with the Regional Behavioral Health Authority or designee. Behavioral health services are integrated into the eligible individual’s Division Individual Support Plan.

The Long Term Care System Audit tool provides information to the Division Support Coordinators regarding the status of their case records for various behavioral health indicators such as the frequency of behavioral health reviews, psychotropic medications, and initial/quarterly consults with a Qualified Behavioral Health Professional.

Behavioral health quality of care issues are discussed on a quarterly basis at the Behavioral Health Liaison Committee meetings, the Statewide Quality Management Committee meetings, and the Division Health Plan meetings and are documented in each meeting's minutes. When the behavioral health treatment issue cannot be resolved at the District level the Division Support Coordinator may request the assistance of a Behavioral Health Coordinator in the Division Office of Managed Care Operations. The Division Behavioral Health Coordinator shall address the issue with the Division Medical Director/Psychiatric Consultant, Regional Behavioral Health Authority personnel or Arizona Department of Health Services/Division of Behavioral Health Services staff. The Division utilizes the Arizona Department of Health Services/Division of Behavioral Health Services Appeals Policy 2.16 when disagreements between the Division and the Regional Behavioral Health Authority about behavioral health treatment issues or the level and types of behavioral health services provided could not be resolved through staffings that are convened to mediate the issue. Issues can also be elevated to a Behavioral Health Coordinator in Managed Care Operations who can then address the issue with the Division Medical Director/Psychiatric Consultant, Regional Behavioral Health Authority personnel, or Arizona Department of Health Services/Division of Behavioral Health Services staff. A quarterly appeals report is distributed at every Behavioral Health Liaison Committee meeting.

Issues involving psychiatric diagnosis, medications and various medical conditions are reviewed by the Division Medical Director or Psychiatric Consultant. As a result of the second level psychiatric reviews, the Medical Director determines if the person is receiving psychiatric medications appropriate to diagnoses, evaluations and treatment supporting the diagnoses, and abnormal involuntary movement scale testing, if applicable.

The Division has registered nurses to assist individuals with developmental disabilities, their families or responsible persons, and Support Coordinators in discharge planning for any member who is in a psychiatric facility. The registered nurses also conduct utilization reviews and identify medical needs that require follow-up on an outpatient basis for members in psychiatric facilities .

Behavioral Health information is included in the Division's Support Coordination Core Training Program. Advanced Behavioral Health training is provided on a statewide basis by the office of Managed Care Operations, which also includes Regional Behavioral Health Authority personnel and providers. Training is also provided when a particular issue has been identified and coordination of care requires enhancement.

In conjunction with the Arizona Department of Health Services, the Division monitors Regional Behavioral Health Authority performance through the Arizona Department of Health Services Quality Management Program. The Division provides Arizona Department of Health Services/Division of Behavioral Health Services with a roster of the Division Long Term Care System individuals on a monthly basis, which Arizona Department of Health Services matches with a list of members who are receiving behavioral health services from the Regional Behavioral Health Authority system of care. On a quarterly basis, quality and utilization reports are submitted to the Division including data on indicators specific to the Division population such as:

a. penetration rate for the Division members;

b. referral to first service timeliness for the Division members;

c. complete annual Title XIX case file review report;

d. utilization cost for the Division members per Regional Behavioral Health Authority;

e. incidence of diagnoses for the Division members; and

f. coordination of care for the Division members;

Local exemplary Regional Behavioral Health Authority practices and Regional Behavioral Health Authority corrective action plans are also included in the Arizona Department of Health Services quarterly reports. This report is distributed to the Division personnel in each District by Managed Care Operations/Behavioral Health Unit so that personnel at the local level can analyze and address any issues that arise as a result of the quality management reports. Information from the local level is elevated to Managed Care Operations/Behavioral Health Unit for tracking and trending purposes. Issues not resolved at the local level are elevated by Managed Care Operations/Behavioral Health Unit either to the Division Statewide Quality Management Committee or Department of Health Services/Division of Behavioral Health Services.

The Division of Developmental Disabilities also conducts Regional Behavioral Health Authority case file reviews of the behavioral health care provided to its members through the Department of Health Services. A random sample of Division Long Term Care eligible individuals who receive behavioral health services are identified by the Department of Health Services/Division of Behavioral Health Services. The results of the case file reviews are submitted to and analyzed by the Managed Care Operations/Behavioral Health Unit who in turn submit the findings to management at the District level. If the case file reviews identify systemic issues the Managed Care Operations/Behavioral Health Unit address those concerns with the Department of Health Services/Division of Behavioral Health. If there are specific issues at the local level, district management staff address those concerns with the Regional Behavioral Health Authorities and their sub-contracted agencies to resolve the issues. Staff from the Managed Care Operation/Behavioral

Health Unit are available to assist in resolving issues at the local level with the Regional Behavioral Health Authorities or their sub-contracted agencies if requested by district management. If the issues cannot be solved at that level they will be elevated by Managed Care Operations/Behavioral Health Unit to the Division Statewide Quality Management Committee or the Department of Health Services/Division of Behavioral Health Services. Issues are tracked and trended until resolution by Managed Care Operations/Behavioral Health Unit.

1404 Arizona Early Intervention Program (AzEIP)

1404.1 Overview

In October of 1986, funding for planning and development of a comprehensive, multidisciplinary, interagency service system for infants and toddlers, birth to three (3) years of age, at risk of disabilities, and their families, was offered by the federal government through the passage of Part C of the Individuals with Disabilities Education Act (IDEA). In response to the federal law, the State of Arizona created the Interagency Coordinating Council (ICC). The State ICC is that body of people who advise and assist with the implementation of Arizona's Early Intervention Program (AzEIP). AzEIP is Arizona's response to the law.

The membership of the ICC is composed of:

a. parents;

b. service providers;

c. a State legislator;

d. a personnel preparation representative;

e. a private pediatrician;

f. a governor appointee; and

g. a representative from:

1. Arizona Department of Insurance;

2. Arizona Department of Economic Security (DES);

3. Arizona Department of Education (ADE);

4. Arizona Department of Health Services (DHS);

5. Arizona Health Care Cost Containment System (AHCCCS);

6. Arizona State Schools for the Deaf and the Blind (ASDB); and

7. Head Start

Throughout the State, at the local level, there are AzEIP teams. These teams advise and assist the State ICC with the implementation of AzEIP by:

a. facilitating community advisory groups in identifying community needs and resources;

b. developing local plans for enhancement of the early intervention system; and

c. providing specified services for children and families who are potentially eligible for early intervention.

Eligibility requirements for AzEIP are noted in Chapter 500 of this Manual.

In addition, there are one or more AzEIP Interim Service Coordinators, contracted by the ICC, who are members of the local team. Interim service coordination is a time-limited relationship focusing on the evaluation/eligibility determination for AzEIP. The role of the Interim Service Coordinator is to provide assistance to those families who need it to connect with service programs. Some families may prefer simply to be given information and proceed independently to obtain an evaluation. The Interim Service Coordinator is the supportive individual who can help the parent with scheduling initial appointments, arranging and providing for transportation, if necessary, and filling out the Early Childhood Services Application (J-008 Appendix 1400.C). This form shall be used by all participating agencies and act as the universal application for children and families seeking early intervention services. If agency specific information is not included on the form, i.e., financial information for application to ALTCS, the Support Coordinator should simply attach a page to the Application documenting information needed in addition to the Application.

The Interim Service Coordinator is not intended to act as the DES/DDD on-going Support Coordinator, however, they will be responsible for assisting the family in identifying immediate needs, beginning the assessment process and facilitating and documenting necessary referrals.

Within 45 days of referral, a DES/DDD Support Coordinator should be identified and a meeting held to develop the Interim Individual Family Service Plan (IFSP). The Support Coordinator is then responsible for assisting the family in accessing resources and obtaining services. (See Section 1404.6.1 of this Manual for further information).

1404.2 Services Funded Under Part C

Part C funds may be used for the following activities:

a. for direct services for eligible children and their families that are not otherwise provided from other public or private sources;

b. to expand and improve on services for eligible children and their families; or

c. to provide early intervention services to children from their third birthday to the beginning of the following school year, or the most logical transition period (See Section 912.4.3 of this Manual), at no cost to the family;

Part C federal legislation recognizes the following as early intervention services and therefore, Part C funds may be used to fund these services when other entitlement, State, or private sources are not available:

a. assistive technology devices and services;

b. audiology;

c. family training, counseling and home visits;

d. health services;

e. medical services for diagnosis or evaluation for eligibility only;

f. nursing services;

g. nutrition services;

h. occupational therapy;

i. physical therapy;

j. psychological services;

k. service coordination;

l. social work services;

m. special instruction;

n. speech/language pathology;

o. transportation;

p. vision services; or

q. other, i.e., respite and other family support services.

34 CFR 303.12

Early intervention services for an eligible child and the child's family may commence before the completion of the evaluation and assessment if the following are met:

a. parental consent is obtained;

b. an interim IFSP is developed that includes:

1. involvement by the Support Coordinator; and

2. a statement of the early intervention services that have been determined to be needed immediately.

c. the evaluation and assessment are completed within the time period required, i.e., 45 days from the date of the referral.

1404.3 Documentation/Tracking of Part C Funds

Part C funds may not be commingled with State funds. As used in Part C, commingle means depositing or recording funds in a general account without the ability to identify each specific source of funds for any expenditure. This requirement for the use of Part C funds shall be satisfied by the use of an accounting system that includes an audit trail of the expenditure of funds awarded under Part C. Part C expenditures will be reported on a quarterly and year end report basis to the Assistant Director, Children's Services Coordinator, District Administrative Services Officers (ASOs) and State level AzEIP office (J-095 Special Project Fiscal Report, Appendix 1400.D). Reporting will be completed and submitted by the Business Operations Unit located in the Central Office with the assistance of the districts and DES Office of the Budget. The reporting schedule is as follows:

1st quarter report due	January 31st
2nd quarter report due	April 30th
3rd quarter report due	July 31st
Final completion report due	January 31st

In no case may Part C funds be used to supplant State and local funds. In order to meet this requirement the total amount of State and local funds budgeted for expenditures in the current fiscal year for early

intervention services must be at least equal to the total amount of State and local funds actually expended in the most recent preceding fiscal year for which data is available, the base level. This statewide base will be established for DES/DDD by the Business Operations Unit no later than January 1st of each year. If there is a significant decrease in the number of children served within the reporting year, the base may be set according to the average cost per child for early intervention services.

1404.4 Payor of Last Resort

Part C funds are to be used as payor of last resort. Funds under Part C may be used only for early intervention services that an AzEIP eligible child needs, but is not currently entitled to under any other Federal, State, local or private source.

Part C funds may be used to serve children who are DDD/AzEIP eligible and DDD/ALTCS/AzEIP eligible. These funds may be used to fund those early intervention services not otherwise provided by ALTCS, State, grants or other public or private sources. In addition, they may be used to expand and improve on services that are otherwise available.

1404.5 Service Coordination/Support Coordination

AzEIP funded Service Coordinators within DES/DDD may serve only DDD/AzEIP eligible children. Children who are DDD/ALTCS/AzEIP eligible shall be served by Support Coordinators funded by ALTCS.

1404.6 Development of Individual Family Service Plan (IFSP)

When a child has been evaluated for the first time and determined eligible for AzEIP, the child's DES/DDD Support Coordinator shall, in cooperation with the child's parents, schedule a meeting to develop an IFSP. Forms to be used include:

a. IFSP Family Information Handout (DD-670, Appendix 1400.H);

b. IFSP Invitations (DD-667, Appendix 1400.I); and

c. Universal Individual Family Service Plan (DD-666, Appendix 1400.J).

The DES/DDD Support Coordinator shall:

a. ensure that the initial meeting is held within 45 days of referral;

b. coordinate and schedule all meetings and notify participants;

c. see that reasonable accommodation is made to ensure that IFSP meetings are conducted at times and in settings convenient to the family;

d. mail notices of meetings, and copies of related documentation including assessments, to meeting participants, at least ten calendar days before scheduled meetings;

e. ensure meetings are conducted in the native language or other mode of communication used by the family, unless it is clearly not feasible to do so; and

f. inform family of established procedural safeguards noted in Section 1404.9 of this Manual.

The intent of the IFSP forms is to document a flexible process that is responsive to:

a. the changing resources, concerns and priorities of the family; and

b. the on-going team process of selecting strategies, activities and services to address the child's needs and the family's concerns.

For an interim IFSP, the team must use:

a. the IFSP Cover Sheet (DD-666, Appendix 1400.J);

b. the Early Intervention Services page (DD-666, Appendix 1400.J.5); and

c. the IFSP Team Page (DD-666, Appendix 1400.J.7).

Other pages are optional at this point. The team should select and use any other pages that are helpful in documentation of current information about the child and about the family resources, concerns and priorities.

For the initial and annual IFSP, the team must use:

a. the IFSP Cover Sheet (DD-666, Appendix 1400.J);

b. the Present Levels of Development pages (DD-666, Appendix 1400.J.1);

c. the Early Intervention Services page (DD-666, Appendix 1400.J.5);

d. the IFSP Team page (DD-666, Appendix 1400.J.7); and

e. the Child Outcomes page(s) (DD-666, Appendix 1400.J.3).

The Family Resources, Priorities and Concerns page (DD-666, Appendix 1400.J.2) and the Family Outcomes page (DD-666, Appendix 1400.J.4) should be used if the family chooses to share information and set specific outcomes, related to the child's development, for the family. The Transition Plan page (DD-666, Appendix 1400.J.6) should be used for any transitions, i.e., transition to school, transition in or out of the hospital or transition from a home based to a center based program that is likely to occur in coming months.

For the six (6) month review IFSP, the law does not require a full team meeting. The family and Support Coordinator are responsible for making decisions about this review process and for documenting changes to the IFSP. It is not necessary to complete a new set of forms at the time of the review. Whenever possible, make changes to the IFSP on the existing forms and add pages as needed. A new IFSP Team page (DD-666, Appendix 1400.J.7) should be completed for the review.

1404.6.1 Interim IFSP

The Service Coordinator, in cooperation with the family, will complete an interim IFSP to ensure timely services while awaiting completion of assessments. The Service Coordinator will document the following:

a. parental consent;

b. name of the Service Coordinator who will be responsible for implementation and coordination with other agencies or persons of the interim IFSP;

c. name of the Service Coordinator's agency;

d. identification of early intervention services which are needed immediately;

e. timelines for those services;

f. identification of further needed assessments; and

g. timelines for those assessments (to be completed within 45 days).

1404.6.2 Periodic Review of IFSP

The DES/DDD Support Coordinator shall ensure that, at a minimum, review and evaluation of the IFSP for a child and family shall be conducted every six months, or more frequently if conditions warrant, or at the parent's request. The purpose of the review is to determine:

a. the degree to which progress is being made toward achieving the outcomes; and

b. whether modification or revision of outcomes or services is necessary.

Conditions which may warrant a review include:

a. child has achieved the identified outcomes;

b. child's and/or family's goals have changed; or

c. there is concern on the part of a provider of services to the child.

The review may be carried out by a meeting or by another means that is acceptable to the parents and other participants. The DES/DDD Support Coordinator shall be responsible for coordination, meeting scheduling and notification of all participants in the review.

The review participants, including the family, shall determine the degree to which progress toward achieving the IFSP outcomes is being made and whether modification or revision of the outcomes or services is necessary. If modification or revisions are necessary, the DES/DDD Support Coordinator shall be responsible for coordination of any new tasks, including:

a. statement of the responsibilities for the completion of the tasks;

b. collection of necessary information; and

c. timelines for the tasks.

As a result of a periodic review, the parents and DES/DDD Support Coordinator may decide it is necessary to schedule an IFSP prior to the annual evaluation. If so, the above procedures for the development of the IFSP shall be followed.

1404.6.3 Annual Meeting to Evaluate the IFSP

A meeting shall be conducted at least annually to evaluate the IFSP for a child and family and, as appropriate, to make revisions. The results of any current evaluations and other information available from the ongoing assessment of the child and family must be used in identifying or modifying outcomes, determining what services are needed and what will be provided.

Participants in initial or annual IFSP meetings or periodic reviews shall include:

a. parent(s) of the child;

b. other family members, as requested by the parent, if feasible to do so;

c. advocate, or other person outside the family, if the family so requests;

d. DES/DDD Support Coordinator working with the family since initial referral of the child for evaluation or designated by a participating agency to implement the IFSP;

e. person or persons directly involved in conducting the evaluations and assessments; and

f. as appropriate, persons who shall be providing services to the child or family.

Meetings are conducted in settings and at times that are convenient to families and in the native language of the family or other mode of communication used by the family unless it is clearly not feasible to do so.

Meeting arrangements and written notice of the meeting must be made using terms understandable to the general public and be provided to the family and other participants early enough before the meeting date to ensure that they will be able to attend. Copies of relevant documentation, to be referred to in the meeting, shall be included with the meeting notice.

If a meeting participant is unable to attend a meeting, the DES/DDD Support Coordinator shall arrange for the person's involvement through other means, including:

a. participation in a telephone conference call;

b. having a knowledgeable, authorized representative attend the meeting to present their written observations and recommendations to the other team members; or

c. submitting assessment observations, service recommendations and other pertinent records to the DES/DDD Support Coordinator prior to the meeting.

The meeting notice shall be provided in the native language of the parents, unless it is clearly not feasible to do so. If the native language or other mode of communication of the parent is not a written language, the public agency/designated service provider shall take steps to ensure:

a. notice is translated orally, or by other means, for the parent, in the parent's native language, or other mode of communication;

b. parent understands the notice; and

c. there is written evidence that the native language requirements have been met.

If a parent is deaf or blind, or has no written language, the mode of communication shall be that normally used by the parent (such as sign language, braille or oral communication).

1404.6.4 Content of IFSP

The IFSP shall be in writing and shall include:

a. statement(s) about the child's status, including:

1. present levels of physical development (including vision, hearing, and health status);

2. cognitive development;

3. communication development;

4. social or emotional development; and

5. adaptive development.

The statements of the child's present levels of development shall be based on professionally acceptable, objective criteria and shall be based on the child's current evaluations and assessments. Statements shall be descriptive and focus on the child's abilities.

b. with the concurrence of the family, a statement of family resources, priorities and concerns related to enhancing the development of the child. If the family so desires, the DES/DDD Support Coordinator shall make available a variety of tools for the family to assess their own resources, concerns and priorities (only as they pertain to enhancing the child's development). The family may or may not choose to request help from a professional. The family then decides which of this information they will share. The process must be informal and non-intrusive to the family.

c. statement of outcome information, in language the family can understand, including:

   1. major outcomes expected to be achieved for the child and family; and

   2. criteria, procedures and timelines used to determine the degree to which progress toward achieving the outcomes is being made and if modification/review of outcomes or services are necessary.

d. statement of the specific early intervention services necessary to meet the unique needs and goals of the child and the family to achieve the identified outcomes. The needs of the child and family shall determine the services to be provided. The DES/DDD Support Coordinator shall ensure that all participants understand that the parents retain the ultimate decision determining whether they, their child or other family members shall accept or decline any services. This statement of early intervention services shall include:

   1. frequency, intensity, and method of delivering the services;

   2. natural environments, including the home and community settings in which children without disabilities participate, in which early intervention services will be provided. It shall contain a statement of the natural environment in which services shall appropriately be provided including a justification to the extent to which any services will not be provided in a natural environment;

   3. location of the services; and

   4. payment arrangements, if any.

   Required definitions are included in Appendix 1400.E.

e. statement of medical and other services needed that are not required by law, to the extent appropriate and the funding sources to be used in paying for the services. This does not apply to routine medical services (immunizations and well-baby care) unless the child needs these services and they are otherwise not available.

   Although these other services may not be provided through AzEIP, the DES/DDD Support Coordinator shall assist the family in accessing them wherever possible. The DES/DDD Support Coordinator shall see that the IFSP identifies steps to secure other services through public and private resources and strategies to help families mobilize or use informal supports, especially if services are limited or unavailable.

f. statement of projected dates for initiation of services;

g. anticipated duration of the services;

h. name of the DES/DDD Support Coordinator (the original DES/DDD Support Coordinator will remain in that capacity or, if determined appropriate, a new DES/DDD Support Coordinator will be appointed from the profession most immediately relevant to the child's and family's needs or who is otherwise qualified to carry out all applicable responsibilities;

i. name of the agency the Service Coordinator represents;

j. demographic information on the child and family, including:

   1. child's name;

   2. child's date of birth;

   3. child's social security number, if available;

   4. parent(s)' name(s);

   5. address; and

   6. phone number.

k. signature of the parent(s) signifying consent to the IFSP;

l. signature of the Support Coordinator, when necessary; and

m. names, titles and agency affiliations of participants.

The IFSP shall include steps to be taken to support transition of the child, upon reaching age three, to preschool services to the extent those services are considered appropriate. The steps include discussion with, and training of, parents regarding future placement and other matters related to the child's transition.

Between the time the child is 2 years 6 months and 2 years 9 months of age, with the parents' consent, the DES/DDD Support Coordinator shall contact the relevant person in the school district to request his or her attendance at a transition planning meeting. With parental consent, the DES/DDD Support Coordinator shall transfer information about the child to the school district, including evaluation and assessment information and IFSPs to ensure continuity of services. Section 912.4.3 of this Manual presents, in detail, the procedures for transition which have been adopted by the Arizona Early Intervention Program.

In addition, the IFSP shall also include the steps to be taken to support the transition of the child into other available services, including steps to help the child adjust and function in the new setting. When the DES/DDD Support Coordinator becomes aware of the need for transition to other early intervention services, (s)he will contact the parents and service providers to find out what needs to be done to make the transition as easy as possible for the child and family (See Section 912.4.3 of this Manual).

1404.6.5 Distribution of the IFSP

The DES/DDD Support Coordinator is responsible for preparation and distribution of the IFSP. Copies of the completed IFSP shall be distributed, within two weeks of the meeting, to the parents and to any team member who requests it. The original, with any related documentation, is retained in the case file.

1404.6.6 Timelines Exception Report

In the event an IFSP cannot be developed within the established timelines, an IFSP completion date shall be determined by the parents and the DES/DDD Support Coordinator and so noted in the case file. The DES/DDD Support Coordinator shall submit an IFSP Timeline Exception Report (Appendix 1400.E) to the state level AzEIP Office within five working days of the expiration of the above timelines.

1404.7 Responsibility and Accountability

The IFSP document cannot commit the resources of agencies or programs without their consent, however, by means of the intergovernmental agreement executed among the participating agencies, it is insured that early intervention services under Public Law

105-17, identified as needed for a child and family, shall be provided as the IFSP directs.

Each agency or person who has a direct role in the provision of early intervention services shall be responsible for making a good faith effort to assist each eligible child in achieving the outcomes in the IFSP. No agency or person shall be held accountable if an eligible child does not achieve the growth projected in the child's IFSP.

1404.8 Procedural Safeguards

The Arizona Early Intervention Program assures that the State has adopted procedural safeguards which insure that the family of each eligible child in the State of Arizona is made aware of, and is protected by, all of their rights under IDEA.

A truly family-focused service delivery system shall be insured from the start. Every effort shall be made to inform families of the services available to them, from eligibility determination to service delivery, to assist them in making well-informed decisions. Families have the right to make choices from available services and have the right to refuse some or all services without risk of losing other services included in an IFSP.

The Department of Economic Security, acting as Lead Agency, assures that it is responsible for the establishment or adoption of procedural safeguards that meet the requirements of Part C. DES is also responsible for ensuring effective implementation of safeguards by each public agency involved in the provision of early intervention services.

The following definitions apply:

a. consent -

1. the parent has been fully informed of all information relevant to activity for which consent is sought, in the native language or mode of communication;

2. the parent understands and agrees in writing to the activity for which consent was sought, following description of the activity and a list of records (if any) to be released and to whom;

3. the parent understands that consent is voluntary on the part of the parent and may be revoked at any time; and

3. the parent has the right to determine whether the infant/toddler or other family members will accept or decline an early intervention service in accordance

with State law without jeopardizing other early intervention services under Part C of IDEA.

b. native language - for persons with limited English proficiency, the language or mode of communication normally used by the parent;

c. participating agency - any agency or institution involved in the provision of early intervention services which collects, maintains or uses personally identifiable information or from which information is obtained under Part C of IDEA; and

d. personally identifiable - information that includes:

1. name of child, parent or other family member;

2. address of child;

3. personal identifiers such as the child's or parent's social security numbers; and

4. list of personal characteristics or other information that makes a child's identity reasonably certain.

1404.8.1 Opportunity to Examine Records

Each participating agency shall permit parents to examine, inspect and review any records relating to their child, which are collected, maintained, or used by the agency, and which relate to evaluations and assessments, eligibility determination, development and implementation of IFSPS, individual complaints dealing with their child, and any other area involving records about their child and/or family. The agency shall comply with a request without unnecessary delay and before:

a. any meeting regarding an IFSP; or

b. any hearing relating to the identification, eligibility determination or placement of the child.

The agency shall comply with the request within no more than 45 days. The needs of infants and toddlers change rapidly during the course of a year, therefore, activities should be completed within the shortest timelines possible. The timelines set forth in this requirement are intended to be the maximum time allotted to accomplish the activities described.

The right to inspect and review records includes:

a. the right to receive full, understandable information about the purpose for which the information shall be used;

b. the right to a response from the participating agency to reasonable requests for explanations and interpretations of the records;

c. the right to request copies of records, if the review and inspection would otherwise be precluded;

d. the right to have a representative of the parent inspect and review the records;

e. the right to challenge the content of personally identifiable data as inaccurate or misleading; and

f. the right to have written instructions on the procedures required to exercise the above rights.

An agency may presume that a parent has authority to inspect and review records relating to his or her eligible child, unless the agency has been advised that the parent does not have that authority, under applicable State law governing such matters as guardianship, separation, and divorce.

1404.8.2 Prior Notice - Native Language

If for any reason an agency becomes aware of a need to determine or review eligibility, diagnosis, needs or services, the family shall have the opportunity to participate in the review.

Written prior notice, using terms understandable to the general public, shall be given to the parents of an eligible child within a reasonable time before a public agency or service provider proposes, or refuses, to initiate or change the:

a. identification;

b. evaluation;

c. diagnosis for eligibility;

d. eligibility determination for AzEIP placement of the child; and

e. provision of appropriate early intervention services to the child and the child's family.

The notice shall be in sufficient detail to inform parents about the action that is being proposed or refused, the reasons for taking the action and all procedural safeguards that are available under Part C of IDEA.

The notice shall include a statement letting parents know that they may agree or disagree with any or all suggested actions. The notice shall be written in language understandable to the general public and provided in the native language of the parents, unless it is clearly not feasible to do so.

If the native language or other mode of communication of the parent is not a written language, the public agency/designated service provider shall take steps to ensure that:

a. the notice is translated orally, or by other means, for the parent, in the parent's native language, or other mode of communication;

b. the parent understands the notice; and

c. there is written evidence that the native language requirements have been met.

If a parent is deaf or blind or has no written language, the mode of communication shall be that normally used by the parent (such as sign language, braille or oral communication).

1404.8.3 Parental Consent

Written parental consent shall be obtained by an agency before:

a. conducting the initial eligibility evaluation and assessment of a child; and

b. initiating the provision of early intervention services (at the time that the initial IFSP is developed).

If consent is not given, the agency shall make reasonable efforts to ensure that the parent:

a. is fully aware of the nature of the evaluation and assessment;

b. is fully aware of the services that would be available; and

c. understands that the child will not be able to receive the evaluation, assessment or services unless consent is given.

If a parent refuses consent and the agency director determines that the refusal constitutes abuse or neglect of the child pursuant to A.R.S. §8-531, a participating agency will have the option to seek a due process hearing.

1404.8.4 Surrogate Parents

The Department of Economic Security shall ensure that the rights of all eligible children, under Arizona's Early Intervention Program, are protected if any of the following apply:

a. no parent can be identified;

b. the public agency, after reasonable effort, cannot discover the whereabouts of a parent; or

c. the child is a ward of the State under Arizona law.

A child who meets any of the tests noted above is deemed to be in need of a surrogate parent. The duties of the Department of Economic Security or other public agency shall include a request to the Court for the assignment of an individual to act as a surrogate for the child. Under State law, a surrogate can only be appointed by a court. Typically, such a request is made at the time of a court order for foster care.

Public agencies shall ensure that a person selected as a surrogate parent under State law has no interest that conflicts with the interests of the child s/he represents and has knowledge and skills that ensure adequate representation of the child.

A person assigned as a surrogate parent may not be an employee of any agency involved in the provision of early intervention or other services to the child.

A person who otherwise qualifies to be a surrogate parent is not an employee solely because s/he is paid by a public agency to serve as a surrogate parent.

A surrogate parent may represent a child in all matters related to:

a. identification, evaluation and assessment of the child;

b. development and implementation of the child's IFSPs, including annual eligibility determinations and periodic reviews;

c. ongoing provision of early intervention services to the child; and

d. any other rights established under P.L. 105-17.

1404.8.5 Impartial Procedures for Resolving Individual Child Complaints

The State of Arizona has chosen to adopt the due process procedures in 34 CFR 300.506 through 300.512. This process includes written procedures for the timely administrative resolution of complaints involving parents on behalf of their children, regarding but not limited to, eligibility determination and assessment of the child, development and implementation of IFSPs and a public agency or provider's proposal or refusal to initiate or change the identification, evaluation or placement of a child in appropriate early intervention services, or the provision of appropriate early intervention services to the child and the child's family.

Complaints shall follow each agency's system for resolution of disputes, consistent with the requirements of 34 C.F.R. 300.506-512. Each agency may utilize informal measures, including mediation, in order to facilitate complaint resolution, however, such informal measures shall not be used to delay or deny parents' access to due process.

If the complaint involves more than one agency, the family may select the agency that they want to administer the dispute resolution process and, if the parents agree, informal dispute resolution procedures. The coordinating agency is responsible for ensuring that the parents are not required to deal with two separate systems by facilitating informal resolution of the matter through the coordination with each affected agency's system and within established timelines.

1404.8.6 Mediation

Mediation is a voluntary dispute resolution alternative to the formal due process hearing. As such, mediation may only be utilized when both parties to the dispute agree to it. Mediation can never be used as a mandatory preliminary step prior to any other administrative or legal recourse. Mediation may not be used to deny or delay exercise of a family's rights under Part C.

1404.8.7 Impartial Due Process Hearing

A parent or a public agency may initiate a hearing on any matters pertaining to prior written notice related to:

a. the public agency's proposal to initiate or change the identification, evaluation or placement of a child or the provision of early intervention services; or

b. the public agency's refusal to initiate or change the identification, evaluation or placement of a child, or the provision of early intervention services.

The hearing shall be conducted by the participating agency which has been assigned as the coordinating agency for the individual child in accordance with State procedures for assignment of a Support Coordinator/DES/DDD Support Coordinator.

The public agency shall inform the parent of any free or low-cost legal and other relevant services available in the area if the parent requests such information or if the parent or agency initiates a hearing.

a. appointment of an impartial person

The hearing shall be conducted by a trained, impartial hearing officer in accordance with the requirements and procedures for that agency or institution and consistent with 34 CFR 300.507. Each agency shall keep a list of persons who may serve as hearing officers. The list shall include a statement of the qualifications of each person listed.

The hearing officer shall:

1. have been trained in the provisions of Public Law 105-17 (AzEIP) and the needs of, and services available for, eligible children and their families;

2. listen to the presentation of relevant viewpoints about the complaint, examine all information relevant to the issues and seek to reach a timely resolution of the complaint;

3. provide a record of the proceedings, including a written decision;

4. not be employed by the agency providing early intervention services to the child or the care of the child, except when a person who otherwise qualifies to conduct the hearing is paid by the agency solely to serve as a hearing officer; and

5. not have a personal or professional interest that would conflict with his or her objectivity in implementing the process.

b. parents' rights in administrative proceedings

The Department of Economic Security, acting as Lead Agency, and in cooperation with the Department of Health Services, Department of Education, School for the Deaf and the Blind, and the Health Care Cost Containment System, assures that the parents of eligible children have the right, in any administrative proceeding, to:

1. be assisted by the DES/DDD Support Coordinator, if appropriate, in the complaint filing process;

2. be informed of any free or low-cost legal services available;

3. be accompanied and advised by an attorney and/or individual(s) with special knowledge or training with respect to early intervention services for eligible children;

4. present evidence, and confront, cross-examine and compel the attendance of witnesses;

5. prohibit the introduction of any evidence at the proceeding that has not been disclosed to the parent at least five days before the proceeding; and

6. obtain written findings of fact and decision and, upon request, a written or electronic, verbatim transcription of the proceeding.

Parents also have the right to have the child who is the subject of the hearing present and to open the hearing to the public.

c. hearing decision and appeal

A decision made in a hearing conducted under this part is final, unless a party to the hearing appeals the decision.

d. administrative appeal and impartial review
If the hearing is conducted by a participating agency other than DES/DDD, any party aggrieved by the findings and decision in the hearing may appeal to the DES. If there is an appeal, DES, or another State agency acting on its behalf, shall conduct an impartial review of the hearing. The official conducting the review shall:

1. examine the entire hearing record;

2. ensure that the procedures at the hearing were consistent with the requirements of due process;

3. seek additional evidence if necessary. If a hearing is held to receive additional evidence, rights related to hearings, as defined above, apply;

4. afford the parties an opportunity for oral or written argument, or both, at the discretion of the reviewing official;

5. make an independent decision on completion of the review; and

6. give a copy of written findings and the decision to the parties.

The decision of the reviewing official is final, unless a party brings a civil action.

d. civil action

Any party aggrieved by the findings and decision in a hearing who does not have the right to appeal to the lead agency or who is aggrieved by the decision of an appeal officer has the right to bring a civil action in State or Federal court.

f. convenience of proceedings - timelines

The administrative hearing process shall be carried out at a time and place that is reasonably convenient to the parents. Efforts shall be made to accommodate the needs of parents and to inform them of any free or low-cost legal and other relevant services available in their area, upon request of the parent, if the parent or the agency initiate a hearing.

A written decision based on the administrative hearing shall be mailed to the parties no later than 30 days after the receipt of the request for hearing.

If either party to a hearing appeals the decision of the hearing officer, the lead agency shall insure that a final decision is reached and a copy of the decision is mailed to the parties no more than 30 days following receipt of the appeal.

A hearing officer or an appeal officer may grant specific time extensions at the request of either party.

1404.8.8 Status of a Child During Proceedings

During the pendency of any complaint or appeal process, unless the State agency and the parents otherwise agree, the child shall continue to receive those early intervention services already being provided. If the complaint involves an application for initial services, the child shall receive those services that are not in dispute.

1404.8.9 Confidentiality of Information

The State of Arizona has adopted policies and procedures to insure the protection of personally identifiable information collected, used or maintained, including the right of parents or guardians to written notice of and written consent to the exchange of this information consistent with Federal and State law.

a. privacy act application

If the Lead Agency or its authorized representatives collect any personally identifiable information regarding children with disabilities, which is not subject to 5 USC 552a (Privacy Act of 1974), the agency director shall apply the requirements of the Statute (5 USC 552a) and the regulations implementing those provisions.

b. notice to parents

The participating agency will give adequate notice to fully inform parents about the requirements under Sections 303-164 and 303.321 of IDEA (Comprehensive Child Find System), including:

1. a description of the extent to which the notice is given in the native languages of the various population groups in the State;

2. a description of children on whom personally identifiable information is maintained, the types of information sought, the methods the State intends to use in gathering the information (including the sources from whom information is gathered) and the uses to be made of the information;

3. a summary of the policies and procedures which participating agencies must follow regarding storage, disclosure to third parties, retention and destruction of personally identifiable information; and

4. a description of all the rights of parents and children regarding this information, including those insured under the Family Educational Rights and Privacy Act (FERPA).

Before any major identification, location or evaluation (child find) activity is conducted, notice will be published or announced in newspapers or other media with circulation adequate to notify parents throughout the State of the activity.

c. accessibility and confidentiality of records

Families have the right to decide how much information to share and to decide who gets information about the family, except under circumstances indicated in this requirement. The parents of an eligible child and their representatives, as identified by the parents in writing, shall have access to any reports, records, clinical eligibility determinations or other information concerning their child's or family's eligibility, needs and services.

d. notice, consent and decision

When an agency identifies a need to determine or review eligibility, diagnosis, needs or services, the family shall be invited to participate in the review. Notice shall be given to the family within a reasonable time and shall include identification of the concerns for review.

Parents have the right to be notified within 24 hours of any known injury or illness and the right to be notified within a reasonable period of time regarding outbreaks of communicable diseases that may affect their child.

e. dispute resolution

If parents disagree with the results of a child's eligibility determination or diagnosis, IFSP goals and objectives, or with proposed placement in early intervention services, they shall be informed about their rights in the complaint process.

The procedures to resolve complaints shall encourage resolution as quickly and easily as possible, at the lowest possible level within an organization, in keeping with the child's and family's best interests. Parents will be informed that they may file a formal complaint and use the informal complaint resolution process at the same time.

Everyone shall concentrate on the best interests of the child and on the family priorities. Disputes shall be resolved quickly. Unless agreed upon by the parent and the agency, there shall be no change made in the services received by the child prior to a final order by a hearing officer.

f. records on more than one child

If any record includes information on more than one child, the parents of those children shall have the right to inspect and review only the information relating to their child or to be informed of that specific information.

g. fees

A participating agency may charge a nominal fee for copies of records which are made for parents, if the fee does not effectively prevent the parents from exercising their right to inspect and review those records. A participating agency may not charge a fee to search for or to retrieve information.

h. amendment of records at parent's request

Parents who believe information in their child's or family's records collected, maintained or used is inaccurate or misleading or violates the privacy or other rights of their child or family may request the participating agency which maintains the information to amend the information.

The agency shall decide whether to amend the information in accordance with the request within a reasonable period of time, but no later than 45 days.

If the agency decides to refuse to amend the information as requested, it shall so inform the parents in writing. Parents shall be informed of their options for resolution, including a hearing, and shall be encouraged to seek informal resolution or mediation to resolve differences. The complaint section of this requirement outlines this process.

i. opportunity for a hearing

The agency shall, on request, provide an opportunity for a hearing to challenge information in records to ensure that it is not inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child and/or family.

j. result of hearing

If, as a result of a hearing, the impartial hearing officer decides that the information is inaccurate, misleading or otherwise in violation of the privacy or other rights of the child or family, the information shall be amended accordingly and the parents shall be informed in writing.

If, as a result of the hearing, the impartial hearing officer decides that the information is not inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child or family, the parents shall be informed of their right to place a statement in the records, commenting on the information or setting forth their reasons for disagreeing with the decision of the hearing officer. The parents' statement shall be placed in the child's records and shall be maintained as a permanent part of those records.

If the child's records, or the contested portion of that record, are disclosed by the agency to any party, the explanation shall also be disclosed to that party.

k. hearing procedures

A hearing held under Section 568 of IDEA shall be conducted under the procedures specified in Section 99.22 of the Family Education Rights and Privacy Act.

l. confidentiality of information

Parents shall be informed about the confidentiality requirements of this law, including the following:

1. a description of the information maintained, types of information sought, methods the State intends to use in gathering the information (including the sources from whom information is gathered), and uses for the information; and

2. a summary of the policies and procedures which participating agencies shall follow regarding storage, disclosure to third parties, retention and destruction of personally identifiable information.

m. consent

Each participating agency shall obtain written, signed and dated parental consent before personally identifiable information can be used for any purpose other than meeting a requirement of this law. Personally identifiable information may be disclosed, without prior written consent,

to officials or employees of agencies who are collecting or using the data and have a legitimate need for access to the information. Information from a record will not be released to a participating agency unless such release is authorized under FERPA, Section 99.31.

The written consent must:

1. specify the records that may be disclosed;

2. state the purpose of the disclosure; and

3. identify the party to whom the disclosure may be made.

When a disclosure is made, and if a parent so requests, the public agency shall provide him or her with a copy of the records that have been disclosed.

The public agency may not release information from the child's or family's records to participating agencies without parental consent, unless required to do so by Federal or State statute or regulation, by a subpoena or by a court order.

n. safeguards

Each participating agency shall protect the confidentiality of personally identifiable information at collection, storage, disclosure, and destruction stages. One official at each participating agency shall assume responsibility for insuring the confidentiality of any personally identifiable information.

All persons collecting or using personally identifiable information shall receive training or instruction regarding the State's policies and procedures under this law.

Each participating agency shall maintain, for public inspection, a current listing of the names and positions of those employees within the agency who may have access to personally identifiable information.

o. record of access

Each participating agency shall be prepared to provide a record of parties obtaining access to the records collected, maintained, or used under AzEIP (except access by parents and authorized employees of the participating agency), including:

1. name of the party;

2. date access was given; and

3. purpose for which the party is authorized to use the records.

p. list of types and locations of information

Each participating agency shall provide parents, on request, a list of the types and locations of records collected, maintained, or used by the agency.

q. destruction of information

Each agency has an internal policy regarding destruction of information that complies with the requirements of State law or the appropriate program standards and with Federal requirements of FERPA and 34 C.F.R. 300.560-567, however, a permanent record of a child's name, address and phone number may be maintained without time limitation. Parents shall be notified and given an opportunity to receive a copy of the information prior to its destruction.

r. enforcement

The lead agency assures that the participating agencies adhere to the requirements and regulations of Part C of IDEA through program reviews and through the complaint system. Sanctions include the removal of funds under Part C.